

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/13/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE (STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HARTFORD ST LAFAYETTE, IN 47904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00123117</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 02/13/13</p> <p>Facility Number: 005003</p> <p>Surveyor: ReBecca Lair, LCSW Medical Surveyor</p> <p>Franciscan St Elizabeth Health-Lafayette Central is in compliance with 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Hospital Licensure Rules.</p> <p>QA: cloughlin 03/13/13</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1